Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN

MR Case Management - 90 DAY ASSESSMENT Z8545

Consumer:_____ Medicaid Number:_____

CSB:_____ Provider Number: _____

Case Manager:_____ Telephone: _____

Start Date: _____ End Date: _____ Quarterly Review Dates: N/A _____ _____ _____

CASE MANAGEMENT OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES
1) Determine diagnostic eligibility. IF DIAGNOSTICALLY ELIGIBLE, CONTINUE. IF NOT, COMPLETE TERMINATION SAR.		Complete SAR for ?90 day? case management and forward to Pre-Authorization Specialist. Start date is the date of the first face-to-face meeting. Review financial situation and assist consumer in applying for SSI and Medicaid, if applicable. Obtain supporting documentation from other sources- medical, psychological, development assessment, etc.
2) Determine the need for active Case Management		Meet with consumer (and parents when appropriate) to discuss and review supports and needs. Determine with consumer/parent(s) if the frequency and level of case management supports require a monthly activity.
3) Coordinate the assessment of consumer?s current situation and strengths in major life areas, and determine service and supports needed within the community.		Complete Consumer Profile/Social Assessment. Assure preferences and interests are included. Complete other formal/informal assessments needed to determine any other case management needs. Meet with consumer/parent(s) to review results of assessments, set personal goals, and identify supports needed.
4) Complete required documentation and maintain in consumer CM record.		Complete per contact case documentation and monthly activity(s). If eligible, forward SAR to Pre-Authorization Specialist for on-going SPO-CM. If ineligible, complete SAR terminating services.

Mental Retardation Community Medicaid Services

_____**NEW** _____**REVISION**
FOR CSP YEAR **FOR CSP YEAR**

INDIVIDUAL SERVICE PLAN

MR Case Management Z8545

Consumer:_____ Medicaid Number:_____

CSB:_____ Provider Number: _____

Case Manager:_____ Telephone: _____

Start Date:_____ End Date: _____ Quarterly Review Dates:_____ _____ _____ _____

CASE MANAGEMENT OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES
1) Coordinate the comprehensive assessment of the strengths and needs of consumer in major life areas and identify supports and services needed in the community.		Complete Consumer Profile/Social Assessment. Coordinate, at least annually, the completion or update of relevant assessments. Involve support providers and significant others in gathering assessment information.
2) Coordinate the completion of the Consumer Service Plan.		Distribute copies of SAR to providers and billing staff.
3) Link the consumer with appropriate community resources and supports, and coordinate with personnel of other agencies.		Complete any needed referrals for newly identified services and complete termination of services no longer desired by the consumer. Obtain needed authorizations/approvals for funding of services from identified agencies.
4) Coordinate the implementation of the Consumer Services Plan.		Assist in the development of and review all Individual Service Plans (ISPs) from providers selected by the consumer.
5) Monitor all services and on-going services to ensure the identified supports being delivered meet the needs and satisfaction of the individual and revise CSP as needed.		Complete at least one activity monthly with/for the consumer, i.e., phone calls, correspondence, visits, etc. to ensure/obtain needed supports (as related to the assessment). At least quarterly (90 days), meet and review with consumer/significant others, supports being provided; satisfaction with services; and to identify any changes or additions requested by the consumer.
6) Complete required documentation and maintain in consumer CM record. (NOT A BILLABLE ACTIVITY, IN AND OF ITSELF)		Complete at least monthly case documentation of activities; quarterly reviews of services provided, documentation of visits/meetings with the consumer, and collateral contacts.

Consumer:_____ Service:_____ Date:_____

CASE MANAGEMENT OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES

Mental Retardation Community Medicaid Services
60-DAY ASSESSMENT INDIVIDUAL SERVICE PLAN

Indicate Service: _____Residential Support _____Supported Employment
Day Support _____ Personal Assistance

ESTIMATED DURATION: **NOT TO EXCEED 60 DAYS**

Consumer:_____Medicaid Number:_____

Code:_____ Provider Name:_____Provider Number:_____

Responsible Person:_____Telephone:_____

Start Date:_____ End Date:_____ Quarterly Review Dates:_____ _____ _____ _____

CSP SELECTED GOAL/ DESIRED OUTCOME: To develop an ongoing plan of training and supports that will best address the consumer?s interests and personal goals for living in the community.

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision)
1) Determine the environments, settings, and activities that best support the consumer?s personal preferences and desires.		Staff will arrange opportunities to participate in a variety of settings and provide experiences in different activities and programs. **Frequency:** Staff will provide assistance and specialized supervision in health care and daily activities throughout the assessment. **Frequency:**
2) Complete functional assessment noting specific abilities, strengths, interests, and areas in which support for assistance and/or training is needed.		Staff will evaluate all life skill areas related to the service and complete the required documentation of observations and assessments. Staff will identity personal preferences that work/don?t work for the consumer. **Frequency:** Staff will assess and document the need for overnight supervision (if applicable). **Frequency:**
3) Develop a written person-centered ISP that includes strategies that will best support the achievement of the consumer?s goals as identified on the CSP.		Staff will develop, with assistance from consumer, case manager, family members, specific objectives, activities, and strategies that correspond to the selected goals on the CSP and match the consumer?s desires, interests and support needs. **Frequency:** If agreed to by consumer, staff will obtain authorization to continue to provide the service.

Consumer:_____ Service:_____ Start Date:_____

CSP SELECTED GOAL/ DESIRED OUTCOME:		
OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision)

CSP SELECTED GOAL/ DESIRED OUTCOME:		
OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (T: Training, A: Assistance, S: Specialized Supervision)

OPTIONAL FORM

Consumer:_____ Service:_____ Start Date:_____

TOTAL HOURS/ UNITS PER WEEK_____

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

COMMENTS:
(Role of other agencies if plan a shared responsibility)

_____ **NEW** **Mental Retardation Community Medicaid Services** _____ **REVISION**
FOR CSP YEAR **FOR CSP YEAR**

INDIVIDUAL SERVICE PLAN

Indicate Service: **XXXX** **Personal Assistance Services** _____ Respite Care ESTIMATED DURATION:_____

Consumer: _____ Medicaid Number:_____

Code: **Z4036** Provider Name:_____ Provider Number:_____

Responsible Person:_____ Telephone:_____

Start Date:_____ End Date:_____ Quarterly Review Dates:_____ _____ _____ _____

CSP SELECTED GOAL/ DESIRED OUTCOME: To receive needed assistance and supervision with personal care and daily activities to live in the community.

OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision)
1) Assist the consumer with personal care and a variety of daily activities. Note: Activities of Daily Living (ADLs) can not total more than 5 hr daily. 2) Assure the consumer?s ongoing health and safety. Note: General Supervision hours can not total more than 8 hrs daily.		Staff will provide **assistance** in the following areas (Specify): Personal Care: _____ Frequency: Monitoring Health/Physical Condition :_____ Frequency: Medication/Other Medical Needs :_____ Frequency: Meal Preparation:_____ Frequency: Housekeeping: _____ Frequency: Accompanying to Meetings and/or Appointments: _____ Frequency: Participation in Recreational Activities:_____ Frequency: Other:_____ Staff will provide **supervision** in the following areas (Specify): Personal Care: _____ Frequency: Monitoring Health/Physical Condition :_____ Frequency: Medication/Other Medical Needs:_____ Frequency: Meal Preparation:_____ Frequency: Housekeeping:_____ Frequency: Supervision to Insure Safety:_____ Frequency: Participation in Recreational Activities:_____ Frequency: Other: _____

Consumer:_____ Service: **Personal Assistance** Start Date:_____

CSP SELECTED GOAL/ DESIRED OUTCOME: To receive needed assistance and supervision with personal care and daily activities to live in the community.		
OBJECTIVES	TARGET DATE	ACTIVITIES/ STRATEGIES (A: Assistance, G: General Supervision)
3) Complete documentation a minimum of monthly on services provided in support plan.		Documentation will include the following: -date/supports provided; -total amount of time (in and out) of service delivery. -signature of persons providing the support. -consumer?s responses and satisfaction with the service provided. (Can use DMAS 90 Aide form). Forward to CSB CM as requested no later than _____ working days following the end of the month for which the service is delivered. Advise CM on the monthly note, if services were not delivered as scheduled.
4) Recommend to CSB CM modifications to ISP as needed, to ensure completion of stated objectives.		Forward revised ISP to CM for approval PRIOR to implementation.
5) Complete quarterly reviews (summaries of services provided and consumer?s response).		Forward to CSB CM as requested no later than _____ working days following the end of the quarter.
ADL hours: _____ Supervision Hours: _____ TOTAL HRS PER WEEK: _____		

OPTIONAL FORM

Consumer:_____ Service: **PERSONAL ASSISTANCE** Start Date:_____

TOTAL HOURS PER WEEK _____

GENERAL SCHEDULE OF SERVICES

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday

COMMENTS:
(Role of other agencies if plan a shared responsibility)

Mental Retardation Community Medicaid Services

INDIVIDUAL SERVICE PLAN - CRISIS STABALIZATION

Z8999 Clinical/Behavior Intervention _____ Z8899 Crisis Supervision_____

Consumer_____Medicaid Number_____

Provider Name:_____Provider Number:_____

Responsible Person:_____Telephone:_____

Start Date:_____ End Date:_____ (Maximum 15 days per authorization; maximum limit - 60 days in a calendar year)

CSP SELECTED GOAL/ DESIRED OUTCOME: To provide direct interventions during a crisis to enable a consumer to remain in his/her community setting.

OBJECTIVES	ACTIVITIES/STRATEGIES (TARGET AUDIENCE)	PROJECTED
1) **Prior to implementation of service**, qmrp will complete a face-to-face assessment to determine clinical interventions needed. This assessment may be conducted jointly with a licensed mental health professional or other appropriate professionals. 2. Determine that **documentation** is present to confirm eligibility for service. 3. Determine that the consumer is ?**at risk?.**	1a) Meet with Consumer face-to-face to confirm current situation and supports needed. b) Give estimated hours of needed intervention to Case Manager for completion of Service Authorization Request. CHECK ALL THAT APPLY: 2) Case Manager or other appropriate personnel, review case notes to confirm that consumer : ____ a) is experiencing marked reduction in psychiatric, adaptive, or behavioral functioning; OR ____ b) is experiencing extreme increase in emotional distress; OR ____ c) needs continuous intervention to maintain stability; OR ____ d) is causing harm to self or others. CHECK ALL THAT APPLY: 3) Case Manager or other appropriate personnel, review case notes, meet with consumer/significant others, to confirm that the consumer is at risk of _____ a) psychiatric hospitalization; OR _____ b) emergency ICF-MR placement; OR _____c) disruption of community status (living arrangement, day placement, or school; OR _____ d) causing harm to self or others.	NOT BILLABLE UNDER CRISIS STABIL.

Consumer:_____ Service: **Crisis Stabilization** Start Date:___ End Date:_____

OBJECTIVES	ACTIVITIES/ STRATEGIES (TARGET AUDIENCE)	PROJECTED HOURS
4. Staff qualified to provide crisis stabilization will provide activities to stabilize consumer in his/her community.	CHECK ALL THAT APPLY: 4) Meet with consumer and/or significant others in consumer?s home, day support setting, respite setting, etc. in order to: ___ a) Complete a psychiatric, neuropsychiatric, or psychological assessment & and other functional assessments; OR ___ b) Review current medication schedule & need for any changes; OR ___ c) Complete/review behavior assessment and/or behavioral support plan; OR ___ d) Complete intense case coordination with other agencies/providers for delivery of supports that will enable consumer to remain in the community; OR ___ e) Complete training for family members/other care givers/service providers in positive behavior supports to enable consumer to remain in the community.	
	TOTAL hours for CLINICAL INTERVENTION	
IF APPLICABLE: 5. As a component of Crisis Stabilization, provide temporary **crisis supervision** to ensure the safety of the consumer & others. (Restricted to staff of licensed Residential or Supportive Residential Services).	5. Supervise consumer, face to face, 1:1 to ensure the safety of consumer. TOTAL NUMBER OF SUPERVISION HOURS	
NUMBER OF **AUTHORIZED** CRISIS STABALIZATION Days year to date: _____		